DRVD
CONFIDENTIAL REPORT

AN INVESTIGATION INTO THE DEATH OF J.S.

40-year-old Caucasian Male Patient
Northern Virginia Mental Health Institute

DRVD CASE # 99-0097
Department for Rights of Virginians with Disabilities
Richmond Central Office
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I. INTRODUCTION

This report is a summary of the findings of the investigation by the Department for Rights of Virginians with Disabilities ("DRVD") into the death of JS, a patient at Northern Virginia Mental Health Institute ("NVMHI").

DRVD conducted this investigation pursuant to the Protection and Advocacy for Mentally Ill Individuals Act of 1986. The investigation included a review of the following:

1. JS's medical records from NVMHI;
2. Root Cause Analysis, Sentinel Event performed by NVMHI;
3. 12-Hour Report of a Patient Death, dated July 9, 1998;
4. Written Statements of NVMHI staff members;
5. Verbal Interviews of NVMHI staff members;
6. Autopsy Report of JS, dated July 30, 1998;
7. Death Certificate of JS, dated August 6, 1998;
8. Barrier Analysis performed by NVMHI;
9. Contract between Fairfax-Falls Church Community Services Board and the Commonwealth of Virginia, NVMHI;
10. NVMHI Policy on Admission Guidelines and Admitting Criteria;
11. NVMHI Policy on Physical Examination;
12. NVMHI Policy on Special Observations;
13. NVMHI Department of Nursing Services Policy on Hourly Rounds;
14. NVMHI Department of Nursing Services Policy on Special Observations;

15. Correspondence between NVMHI, the NVMHI Local Human Rights Committee, the Northern Virginia Mental Health Consumers' Association, and DRVD;
16. Letter of Findings to Governor George Allen from Assistant Attorney General Deval L. Patrick, dated April 20, 1995;
17. U.S. Justice Department reports on findings of Dr. Robert Bernstein, Licensed Psychologist, relating to NVMHI, site visit of July 25-27, 1995;
18. U.S. Justice Department reports on findings of Jane A. Ryan, RN, relating to NVMHI, site visit of July 25-27, 1995;
19. Supplemental Findings, DOJ report in letter from to Governor George Allen from David Deutsch, dated April 3, 1996;
20. NVMHI Plan for Continuous Improvement, dated June 2, 1997;
21. Settlement Agreement and Order between the United States and the Commonwealth of Virginia, Dated June 10, 1997;
22. Letter dated January 4, 1999 to Jane Hickey, Office of the Attorney General, from David Deutsch, Senior Trial Attorney, U.S. Justice Department;
23. Modification of Settlement Agreement;
24. Consultation Report of Dr. Darrell G. Kirch, dated December 28, 1998;
25. Consultation Report of Dr. Darrell G. Kirch, dated September 26, 1999;
26. Report on Consultation Relating to Northern Virginia Mental Health Institute for the United States DOJ by Robert Bernstein, Ph.D., dated October 28, 1999;
27. Report of Technical Assistance Visit to Northern Virginia Mental Health Institute on August 17-19, 1999, by Jane Ryan RN, MN, CNAA for United States Department of Justice.

II. BACKGROUND

A. The Facility

NVMHI, located in Falls Church, Virginia, is a 137-bed, inpatient psychiatric facility licensed and operated by the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services ("DMHMRSAS"). The facility is accredited by the Joint Commission on Accreditation of Health Organizations ("JCAHO") and provides diagnosis and treatment of mental disorders for adults.

In 1995, the United States Department of Justice ("DOJ") conducted an investigation of NVMHI pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. sec. 1997 et seq. DOJ submitted its findings to then Governor George Allen, with recommendations for improvement. On June 10, 1997, DMHMRSAS reached a settlement

agreement based on violations DOJ found during its investigation. This agreement required NVMHI to institute its Plan for Continuous Improvement by January 1, 1999 and allowed DOJ to monitor Virginia's implementation of the Plan.

B. The Patient

JS was voluntarily admitted to NVMHI on July 8, 1998. This was his ninth admission into the Commonwealth of Virginia's mental health system and his fifth admission to NVMHI. JS had been prescreened by Dr. "RM" of Woodburn Mental Health Center ("Woodburn"), after presenting with suicidal ideation and auditory hallucinations that had intensified over the two weeks preceding his 7/8/98 admission. His admitting diagnoses were: major depression, recurrent with psychotic features; hypertension; urinary tract infection; muscle spasms; and a history of renal stones.

JS's medical records document a history of hypertension, a urinary tract infection, exogenous obesity and muscle spasms. The records also indicate that upon admission, JS had three medications in his possession: Augmentin, Cardizem CD and Corispradol (Soma). At Woodburn, JS was noted to be obese and diaphoretic. No vital signs were reported to have been taken at that time. Dr. "RM" said that he spent two hours with the patient, but he did not elicit any more clinical data and did not express any specific concerns about his medical or psychiatric status.

III. CIRCUMSTANCES SURROUNDING THE INCIDENT

JS was transported by Woodburn to the admissions unit at Northern Virginia Mental Health Institute between 9:30 and 10:00 p.m. on July 8, 1998. The NVMHI on-call physician, Dr. "CH", discussed the case with Woodburn's physician, Dr. "RM". Dr. "RM" had diagnosed JS with major depression and psychotic features, and the two doctors decided not to initiate psychotropic medication until Dr. "CH"'s evaluation the next morning. Dr. "RM" also diagnosed JS with hypertension, which was longstanding and for which he was under the care of a Primary Care Physician. Dr. "RM" did not have any specific discussion with Dr. "CH" regarding continuation of the patient's current medications, which included Cardizem, Atenodol and Augmentin.

JS was admitted to NVMHI upon the telephone order of Dr. "CH"; Dr. "CH" was not physically present at NVMHI at that time and did not examine JS. Dr. "CH" did contact Dr. "YK"--who had treated JS previously--and was informed that JS made frequent office visits (every 2-4 weeks) with various low-level medical problems and complaints. Dr. "YK" classified JS as "med-seeking" and addicted

to opiates. JS had been seen on July 6, 1998, for "flu-like illness." His anti-hypertensive medication dose was increased, he was prescribed Demoral 50 mg (50 tablets dispensed) for pain. Atenelol and Soma were continued and a new prescription for Viagra was provided. He was also on Augmentin for a urinary tract infection.

According to staff, JS looked "tired" and was dozing off when he arrived at NVMHI. During the intake process, JS was cooperative but continuously stated, "I'm sorry I'm not cooperating." The Nursing Admission Assessment described his cognitive functioning as oriented as to time, place, and person, but difficulty with concentration. According to NVMHI records, upon admission JS's vital signs were as follows: temperature – 100 degrees F; pulse – 114; blood pressure – 140/100. The Nursing Admission Assessment noted the patient reported that he "takes more prescription medications than prescribed."

At the time of his arrival, the unit was short-staffed; there were only 3 RNs and 2 psychiatric technicians. NVMHI standards normally would require six staff people for the number of patients on the admissions unit, depending upon experience and skill level of those assigned. At the time JS was admitted, both psychiatric technicians were probationary, and one had just transferred from another unit within the several days preceding JS's admission. The evening charge nurse divided the admission process so that one RN would do the nursing admission assessment, one would do the order, and the third would do the admission checklist and vital signs. The one who started the nursing admission assessment was "borrowed" from another unit. The RN assigned to the unit completed the initial treatment and nursing care plan in order to allow the first RN to return to her assigned unit.

After admission, JS was confined to the unit, placed on checks every 15 minutes for safe presence and prescribed Klonopin for anxiety. He asked to take a shower, so staff provided towels and shampoo. JS took a shower, then ate a sandwich. JS fell asleep for about 5-10 minutes, then a staff member woke the patient up to go through his gym bag. JS was cooperative, then fell back asleep. Staff reported that sometime between 11:00 p.m. and midnight, JS's roommate came out stating he could not sleep because JS was snoring.

At approximately 12:00 a.m., "AS", a psychiatric technician, noted that JS's name was not on the list of special observation patients on the rounds board. "AS" mentioned this to the other technician, who told her that the RN has to add his name to the sheet. She then took the board to the charge nurse who added the patient to the sheet, and began to do 15-minute checks. At the time of the incident, the practice for doing rounds and checks consisted of a technician opening the door and noting the presence of each patient in his or her bed. The

technician did not go into the individual patient rooms or around the patients unless a patient was out of bed or the technician had been specifically directed to do so by the RN. There were three patients on these checks on JS's unit.

"DG", another psychiatric technician, stated in an interview that at approximately 12:15 a.m., JS was lying on his stomach in "prone" position and facing the wall. He was observed breathing. At approximately 1:00 a.m., JS's roommate was returned to his room because JS was no longer snoring. Approximately 2:00 a.m, "DG" observed JS lying on his side in "Sims" position, facing the entrance room door. Staff reported that JS was checked every 15 minutes and observed apparently sleeping. For the rest of the night, JS remained in the same position. At some point around 5:00 – 5:15 a.m., JS's roommate briefly "popped" out of his room, looked around, and went back into the room.

Around 6:35 a.m., "AS" was performing wakeup calls. She called JS's name aloud, and reminded him of the physician's order for a urine specimen. JS did not respond, so "AS" came closer to the bed, calling him by his name. She touched him slightly and shook him, but received no response. "AS" then noticed that JS apparently was not breathing, and called the charge nurse, "RJ". "RJ" reported that "AS" came into the room "in a panic," saying "you've got to come—I think we have a problem. I can't wake [JS] up—he's not responding. I think he's gone." "RJ" immediately called the nursing supervisor ("CH"), grabbed a resuscitation mask and gloves and went to JS's room. Nurse "MD" was already with JS, who was lying on the right side of his stomach with his right hand under his cheek. "MD" noted in the patient's record: "Body cold to touch and rigid." Nursing supervisor "CH" observed that the patient's leg was cold and discolored, and noted in the medical record that "the patient's legs were cold to the touch. There was no evidence of breathing and the patient's lips were cyanotic." The charge nurse, "RJ", noticed that JS was very cold to the touch upon her arrival to the patient's room. She sent an RN for gloves for herself prior to attempting to turn JS over. They turned JS over, and discovered he was "very rigid, his arms were drawn up over his chest and face." Some red liquid blood was observed coming out of his mouth. Three members of the nursing staff started CPR at approximately 6:37 a.m., but it was very difficult to perform due to the rigidity of the JS's body. The CPR consisted of respirations, chest compression, and one-minute pulse checks, which indicated no pulse. The rescue squad arrived at 6:45 a.m. and discontinued CPR, noting that JS had already expired and that CPR was no longer necessary.

Nurse "MD" went to retrieve JS's paperwork. She went to the medication room for his medication administration record and to the report room to get the "ID Notes for Special Observations." While in the report room, "MD" came across additional paperwork which had not been completed or incorporated into JS's

medical chart: Community Living Standards, the database sheet, and "one other form." At this time, she noted the patient's vital signs and showed them to "RJ". There was no mention of the irregularity of the vital signs during the report from evening shift.

The Report of Autopsy, issued on July 31, 1998, determined that JS's cause of death was hypertrophic cardiomyopathy.

IV. REVIEW OF THE INCIDENT BY NVMHI LHRC

On December 10, 1998, the Local Human Rights Committee (LHRC) of NVMHI conducted an inquiry into the death of JS at the request of the Northern Virginia Mental Health Consumers Association ("NVMHCA"). The LHRC met with the facility director and the patient advocate to discuss concerns surrounding the death of JS, to review the client record, to obtain information concerning the delivery of medical care at NVMHI, and to make systems recommendations concerning human rights issues identified.

During its inquiry, the LHRC learned that NVMHI had made several changes in response to JS's death, based on recommendations for improvement identified in the hospital's "Root Cause Analysis." As of the date of the LHRC inquiry, the following changes had been reported:

1. NVMHI significantly revised procedures and policies for the delivery of medical and nursing care. Also, new algorithms were developed to serve as an improved guide to the delivery of medical services.
2. The facility took disciplinary actions against staff and renewed its commitment to further staff training.
3. The facility developed a new protocol for suicide assessment.
4. NVMHI had secured 24-hour medical coverage through full-time medical staff. There was an internist and/or family practitioner on site at all times around the clock.
5. Due to the 24-hour medical coverage currently available, the contractual arrangement for on-call medical services from the Woodburn Mental Health Center was terminated.
6. NVMHI adopted a temporary policy to no longer admit patients after hours or on weekends.

In a letter dated December 14, 1998, from the NVMHI LHRC to the Northern Virginia Mental Health Consumers Association, the LHRC noted the above changes "as further developments to providing a safe and therapeutic environment at NVMHI. . . . the LHRC is satisfied that NVMHI has taken the necessary steps in response to the incident."

V. FINDINGS

A. NVMHI Policy Did Not Require an Adequate Medical Evaluation at the Time of Admission

At the time of the patient's death, NVMHI did not provide 24-hour on-site physician coverage. JS was admitted at night and there was no physician on the hospital grounds to assess his condition. The on-call physician was only available by phone, which prevented him from providing an adequate medical assessment of JS. He relied only on the poorly documented information provided by Woodburn and NVMHI staff.

Medical evaluation standards for admission to the facility were inadequate in policy and practice. The Medical Staff policy on Medical Clearance and the NVMHI policy on Admissions Criteria and Physical Examinations were not sufficiently detailed to ensure the prompt and adequate assessment of medical needs by qualified medical staff. The requirement that a health and physical evaluation be conducted within 24 hours was inadequate in the presence of serious medical problems.

B. The Admitting Physician at Woodburn Failed to Perform an Adequate Medical Evaluation of JS, or to Communicate Effectively with NVMHI Staff

The admitting physician at Woodburn Mental Health Center, Dr. "RM", did not meet the expected standard of care. He did not record vital signs or conduct a physical evaluation prior to admission at NVMHI. Although Dr. "RM" said that he spent two hours with JS, he only asked routine questions related to medical issues and did not attempt to fully evaluate the patient's medical status. JS was on three medications indicative of serious medical conditions—Augmentin, Cardizem, and Corispradol—but Dr. "RM" had no specific discussion regarding JS's current need for these medications.

In his communications with Dr. "CH", the on-call physician at NVMHI, Dr. "RM" did not adequately discuss the serious medical, medication, and treatment needs of JS. Dr. "RM" was aware of the patient's medical history, including hypertension and urinary tract infection, but failed to discuss the immediate treatment for these conditions with Dr. "CH" at NVMHI. He neither explored the possible causes of nor followed-up on his observation that the patient was diaphoretic and hypertensive.

It is important to note that the contract between NVMHI and the Fairfax-Falls

Church Community Services Board dated July 2, 1998 did not require Woodburn to perform a medical evaluation; however, the agreement states that Woodburn psychiatrists will evaluate ". . . other emergencies that require the presence of a psychiatrist."

C. The On-Call Physician at NVMHI did not Perform an Adequate Medication Evaluation of JS Following Admission nor Communicate Appropriate Orders to NVMHI Staff

Dr. "CH" failed to properly discuss JS 's medical condition and medications with Dr. "RM" at Woodburn, and did not relate the minimal information that he obtained to the NVMHI staff. He did not give orders to treat JS's medical conditions--which included hypertension and a urinary tract infection--nor did he address JS's substance abuse issue. The fact that JS was on medications for these medical conditions prior to admission was apparently ignored. According to NVMHI Policies and Procedures on Admission Guidelines and Admitting Criteria, Policy #A-10-A, effective May 1997, V.A.1(a), "individuals with significant acute or chronic medical conditions shall be medically stabilized and have written medical clearance by a qualified physician prior to acceptance for admission unless waived by the Director of Medical Services or designee." Dr. "CH" did not ensure that Dr. "RM" had adequately assessed JS's medical condition and did not obtain the information necessary to determine that JS was medically stable upon admission to NVMHI. Although this policy states that all patients who are admitted to NVMHI are pre-screened psychiatrically through the Community Service Boards, NVMHI maintains the responsibility for ensuring that the medical needs of the patient can be provided by the facility. If not, arrangements must be made for the patient to be treated in another facility. Dr. "CH" did not make arrangements, with the exception of a recommendation for examination the next day, to provide treatment for JS's medical needs.

D. The Nursing Staff did not Complete an Adequate Admission Assessment and Nursing Care Plan

Admissions: Communication between the admitting and charge RNs was incomplete regarding the findings of the nursing assessment. The admitting RN did not follow-up on the patient's documented abnormal vital signs with an appropriate plan of care. She also failed to give a report to the charge or other unit nurse on the patient's admission assessment, including the abnormal vital signs. According to NVMHI Policies and Procedures on Admission Guidelines and Admitting Criteria, Policy # A-10-A, effective May 1997, V.A.1., "The Admissions Coordinator will identify all individuals with significant acute or chronic medical conditions, special nursing care needs, or

physical disabilities at the time of the initial referral." Although JS was placed on special observation with fifteen-minute checks, he was initially not placed on the rounds board to alert other staff to his special status.

The Charge Nurse: There was a lack of overall coordination of the admissions process by the Charge Nurse. The admission assessment was divided between two or three RNs, resulting in a lack of continuity and coordination. The nursing assessment process was left incomplete after JS's admission.

Night Shift Nursing Staff: Following admission, there was no nursing assessment of the patient during the night shift. The nursing policy for special observations required documentation by an RN every 24 hours to evaluate patient conditions. This policy was insufficient due to the serious medical condition of the patient.

Adequacy of Nursing Staff: Nurses were not adequately trained related to the medical/physical assessment of patients. Further, there were insufficient nurses to provide adequate care. At the time of JS's death, there were 27.5 nursing staff vacancies at NVMHI.

E. Psychiatric Technicians did not Adequately Perform Required Special Observations of JS

NVMHI policy required psychiatric technicians to observe the patient for respirations or skin color during special observations. It is apparent from the medical records and staff interviews that JS had been dead for some time prior to his discovery by the psychiatric technician. Staff members reported that JS was "stiff," "cold" and "discolored," which are clear indicators of rigor mortis. Although the psychiatric technicians stated that they observed JS every 15 minutes, it is not possible that these observations were properly performed. Notations in the record are limited to the body position of JS, with no observation of respiration or skin color.

The psychiatric technicians on duty at the time of JS's death lacked necessary training and experience to provide adequate care to NVMHI patients. There were only two psychiatric technicians on duty the night of JS's death, both of whom were recent hires.

VI. CRIPA INVESTIGATION OF NVMHI BY THE UNITED STATES DOJ

Between July 1995 and the present, NVMHI has been subject to a federal investigation by DOJ. To the extent that DOJ's investigation focused on the medical care and treatment provided at NVMHI, it is important to discuss the

findings of DOJ that are directly relevant to the conditions at the facility which contributed to JS's death, and actions being taken by NVMHI to address those findings.

On July 25-27, 1995, representatives of the United States Department of Justice conducted an on-site inspection and evaluation of NVMHI as part of its investigation pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. §1997 *et seq.* As a result of these examinations and inspections, the United States advised the Governor of Virginia (then Governor George Allen), in letters dated April 20, 1995, and April 3, 1996, that conditions at NVMHI constituted a pattern or practice of violations of the constitutional and federal statutory rights of NVMHI patients.

During its investigation, DOJ found that conditions at the facility deprived NVMHI patients of their constitutional rights and violated the Americans with Disabilities Act ("ADA"), 42 U.S.C. §12101 et seq., Section 504 of the Rehabilitation Act of 1973 ("Section 504), 29 U.S.C. §. 794 et seq., Title XVIII of the Social Security Act ("Medicare"), 42 U.S.C. § 13951 et seq., and implementing regulations for those statutes. Specifically, the Justice Department found that NVMHI failed to provide adequate mental health and medical care, failed to protect patients from harm, and failed to maintain adequate staffing and safe physical conditions.

The Justice Department noted several remedial measures necessary to meet constitutional and statutory requirements. With regard to staffing, NVMHI must retain adequate numbers of qualified professional and direct care staff to develop and implement treatment programs and care for patients and provide appropriate supervision. To ensure adequate medical care and medication practices, medical staffing must be adequate to ensure prompt professional evaluation of medical problems by a regular medical doctor.

In response to these findings, the Commonwealth submitted a Continuous Improvement Plan ("The Plan") on June 2, 1997, which set forth the improvements that NVMHI agreed to make by the notice date, broken down into the following categories: Mental Health Care, Staffing and Staff Supervision, Medical Care and Medication Practices, Seclusion and Restraint and Protection from Harm, Physical Plant Issues, and Performance Improvement and Record keeping.

In anticipation of the execution of a settlement agreement, The United States filed a Complaint in United States District Court against the Commonwealth of Virginia on June 10, 1997, based on the above violations. Also on June 10, 1997, the two parties agreed that NVMHI would institute its Plan for Continuous Improvement

by the notice date in the Agreement, January 1, 1999 (which was later extended to January 1, 2000). The Agreement also allowed the United States an opportunity to observe Virginia's implementation of the Plan through consultation tours, interim reports, and certification tours.

July, 1998 Consultation Visit by Dr. Jeffrey Geller

At the request of the Commonwealth of Virginia, Dr. Geller made a consultation visit to NVMHI after JS's death and another death at the facility one month earlier. With regard to medical care and admissions, he found that 1) better evaluation and tracking of admission risk factors was required, and 2) better medical screening at admission and on site 24-hour medical coverage were needed.

October 28, 1998 Site Consultation Visit

In response to JS's death and another death at NVMHI in 1998, the U.S. Justice Department conducted a consultation site visit at NVMHI. The site visit included Dr. Darrell G. Kirch, who released a report of his findings on December 28, 1998. Dr. Kirch found that based on information regarding JS's admission and treatment at the facility, "it would appear that the initial medical evaluation of the patient and the medications he had been taking was not adequate, communication regarding these problems was lacking, and the quality of overnight 'observation' of the patient was seriously deficient." Dr. Kirch also noted the "apparent breakdown in the evaluation and treatment of medical-surgical problems, both at the community level in admission evaluation and at NVMHI."

The Modification of Settlement Agreement

In the "Modification of Settlement Agreement," dated December 22, 1998, NVMHI agreed that they would "ensure that all patients are afforded adequate preventative, routine, specialized, and emergency medical and nursing care by December 15, 1998." This component of the agreement included, among other things:

1. NVMHI will have sufficient physician staff to provide adequate medical coverage at all times.
2. Qualified nursing staff will conduct a comprehensive nursing assessment for each patient that includes system review and identification of medical problems in addition to assessment of mental/psychological functioning.
3. NVMHI medical and nursing staff will identify patient health care problems and develop and implement an appropriate and adequate medical and nursing care plan for these problems for each patient as part of the comprehensive treatment planning process.
4. Patients will receive prompt evaluation of all health care problems. All patients who have medical complaints, exhibit symptoms of illness, or are

injured will be promptly examined by a nurse practitioner or a physician, and appropriate treatment and/or referrals instituted. Treatment will include an adequate physical assessment and documentation commensurate with the patients' changing clinical needs. This requirement will be monitored by the Medical Director and corrective action taken when necessary.

5. Medical and nursing staff will identify patients at increased medical risk, including, but not limited to, patients at risk for developing weight loss, dehydration, constipation, decubitus ulcers, dysphagia and aspiration. Patients identified at higher risk will be monitored by medical and nursing staff, both to prevent the development of these problems, and to treat any that do develop.
6. NVMHI will develop and implement a Quality Systems Oversight Instrument to monitor patient care to ensure that each patient's medical care plan and physician's orders are implemented as ordered.
7. Direct care nursing staff will monitor each patient's physical and psychiatric status according to physician orders. Registered nurses (RNs) are responsible for the assessment and observation of each patient. RNs are responsible for identifying significant alterations in patient status and for immediately notifying the physician of those changes.
8. There will be a licensed physician, specializing in internal medicine or family practice medicine, on site 24 hours every day of the week.
9. Policies and procedures related to medical care delivery will be developed and implemented to ensure that:

    a. The Medical Director will provide leadership to and oversight of the medical staff on best practice for medical/psychiatric patient care.
    b. RNs will immediately notify and have immediate access to a physician in cases of a medical emergency. Policies and procedures will be jointly developed between the Medical Director and Director of Nursing and will be widely disseminated to unit nursing staff on all shifts.

<u>Consultation Site Visit by U.S. Justice Department on July 26-28, 1999</u>

The U.S. Justice Department visited NVMHI on July 26-28, 1999, in order to further assess the progress made by NVMHI in the implementation of its Plan for Continuous Improvement dated June 2, 1997. Reports of this visit were submitted by Darrell G. Kirch, M.D., Robert Bernstein, Ph.D., and Jane Ryan, RN, MN, CNAA , all of whom took part in the consultation at the request of the Justice Department.

Consultants reported that although NVMHI had made progress in instituting the Continuous Improvement Plan--especially in the areas of medical care--the facility still required additional steps to achieve compliance with the Plan. The

consultants still found deficiencies in medical documentation and focused on one factor "that very well may outweigh all others in impeding progress" - staff turnover.

VII. CONCLUSIONS

A. The Death of JS

Based upon this investigation, DRVD concludes that NVMHI failed to provide JS adequate medical care, which directly contributed to his death at that facility on July 9, 1998. This conclusion is based upon the failure of the admitting and on-call physicians, nursing staff, and psychiatric technicians to meet the standard of care expected of providers of mental health treatment.

B. Facility Conditions

Based upon this investigation and the well-documented history of institutional deficiencies noted during the ongoing CRIPA investigation by DOJ, DRVD finds that from July 1995, until the death of J.S. in July 1998, NVMHI failed to provide adequate medical and mental health treatment. Following the deaths of two patients – JS and SN in July 1998, NVMHI has taken significant steps toward improving the quality of care provided at the facility, including substantial compliance with remedial measures required by the Settlement Agreement with the U.S. Justice Department. However, it is imperative that NVMHI fully comply with the 1997 Continuous Improvement Plan, as revised. Until the Plan is completely enacted and fully functioning, NVMHI is not providing optimal care to individuals with mental illness in the Commonwealth of Virginia.

VII. RECOMMENDATIONS

A. Continue to Provide 24-Hour Medical Coverage by a Qualified Physician at NVMHI

Since August 1998, NVMHI has provided 24-hour medical coverage at the facility. The facility has a full-time staff internist supported by contract primary care physicians to provide on-site coverage around the clock. Several contractual agreements with facilities and physicians provide both acute emergency and non-acute medical and surgical consultation and services. Dr. Kirch observed in his July 1999 visit that "access to the full range of medical care is in place and appears to be used appropriately by the primary care physicians and psychiatrists on staff." He noted that "[t]he steps taken by NVMHI to strengthen the initial medical-surgical assessment of patients do

appear to be effective." Availability of physicians 24-hours per day is essential to providing adequate medical care. NVMHI must continue to provide this care to its patients.

B. Continue to Develop Algorithms for Procedures to Follow When Caring for a Medically Difficult Patient

In her report, Jane Ryan recommended that NVMHI develop algorithms for use by the medical and nursing staff for procedures to follow when caring for a medically difficult patient. To date, algorithms for six common medical problems encountered in the NVMHI setting have been developed.

C. Provide a Full Physical Examination of each Patient within 8 Hours of Admission

The current standard for examination of patients is within 24 hours of admission. Although NVMHI Administrative Policy #A-10-A requires an individual to be cleared medically and accepted by an attending psychiatrist at NVMHI prior to admission, the facility still only requires a full History and Physical Examination within 24 hours. Because NVMHI now has a medical doctor at the facility at all hours, the facility should ensure that patients receive a prompt examination.

D. Fully Implement Medical/Nursing Policy #M-22, Which Enables Nursing Staff to Maintain Communication with On-Call Physician at All Times

At the time of JS's death, it was NVMHI policy that all calls to the physician on duty were routed through the nursing supervisor. The staff person would call the nursing supervisor who would then assess the need for a physician. NVMHI instituted a new policy on June 8, 1999 that permits RNs to directly call the medical physician on call to discuss patients who are medically ill and need immediate attention. Non-urgent calls to the medical doctor on-duty and psychiatrist on-duty will continue to be clustered by the nursing supervisor.

E. Ensure that Medical Staff are Properly Trained

As of July 1999, Justice Department consultants found that the continuing medical education programs of the facility required strengthening. It is important that medical staff be properly trained on standards of care and treatment, as well as hospital procedures, and that they follow them.

At the time Dr. Kirch last visited NVMHI for consultation, the written orientation and training manual for medical staff had been under development

for over two years and remained incomplete. The NVMHI Acting Facility Director has completed the manual and began distributing it January 3, 2000. All new medical staff hires now receive the manual upon arrival and are fully trained in the policy and procedures before beginning employment. Current staff will receive training under the new manual within the first quarter of 2000, along with training on the new medical staff bylaws, which will be complete by February 1, 2000.

In conjunction with the new medical staff bylaws and Training Manual, NVMHI has instituted a system of competency evaluation for all medical staff. All medical staff must complete necessary training—including continuing education—and follow hospital procedures to receive satisfactory competency evaluations. Failure to meet minimum standards will result in disciplinary action for the medical staff.

It is important to note that in response to the death of JS and that of SN during 1998, NVMHI did pursue corrective action against those who did not follow necessary procedures. According to NVMHI administrators, members of medical staff resigned in lieu of pending disciplinary action.

F. Ensure that Nursing Staff are Properly Trained

Proper education and training of the nursing staff is critically important. In response to the Modified Settlement Agreement of 1998, which required standards concerning the care of the medically ill patient, the Nursing Department hired consultants to develop and teach courses about the care of the medically ill patient and develop policy and procedures for that care. Courses that were developed and taught included *RN's Responsibility/Role in Managing Care of Patients Exhibiting Changes in Physical Status*, *Assessment and Maintenance of Patient Physical Well-Being*, and *Assessment of Physical Status*. NVMHI is currently exploring an ongoing contract with the provider for updates and annual competencies.

On October 22, 1998, NVMHI enacted a Nursing Policy on Registered Nurse Assessment to Assure Patient's Physical Well-Being. The policy provides direction for nursing staff for the on-going assessment of a patient's physical condition. The policy includes procedures of assessment on admission, patients with physical complaints, changes in physical status, unusual or suspicious circumstances, and the documentation required for each event. Nursing staff must be properly trained on these procedures and ensure that they are followed. Nursing staff who do not adhere to this policy should be subject to disciplinary action.

Additionally, the Nursing Admission Assessment was revised to include a systems review and identification of physical problems. The Nursing Department Monitoring and Evaluation Summary provides monthly data about the percentage of compliance with documentation criteria established for Medication Education, Nursing Assessment, Nursing Progress Notes and Seclusion Room/Restraint Care. The process was revised to strengthen the criteria only a few months prior to Jane Ryan's consultation visit, and although the criteria had been implemented, many of them did not meet the threshold of 94% compliance. The stricter criteria are certainly an improvement, but nursing staff need to follow the criteria in order for the process to be effective. In the last quarter of 1999—after Ryan's visit—compliance had improved and most of the criteria, but still not all, now meet the 94% threshold.

Jane Ryan recommended in her report that classes should be offered to nursing staff to inform them about the new documentation criteria and share the results of the first months of monitoring under the new criteria. She also recommended that the hospital develop a program to identify excellence in transmission of patient information during a shift report. This could serve as a model for other RNs to identify the important ingredients for communication of patient progress or lack of progress. DRVD supports this recommendation and advises NVMHI to initiate this program as quickly as possible.

G. Ensure that Psychiatric Technicians are Properly Trained

It was evident in this investigation of JS's death, as well as Justice Department consultations, that the psychiatric technicians have not been properly trained to provide the expected standard of care. Psychiatric technicians must be properly trained on the procedures for making rounds and special observations. The Nursing Policy on Hourly Rounds, enacted September 10, 1998, requires that two staff members perform all hourly rounds. When a patient appears to be resting or sleeping, staff are to walk up to the person in the bed to ensure that he or she is not in distress and that the person who should be in bed is, in fact, there. The patient must be observed for respirations, skin color, and body position, then listen to the patient breathing as well as observe chest movement. When the patient's room is dark, staff must use flashlights to check on the patient, while ensuring minimal disturbance to the person.

Although the Director of Nursing has made significant progress in strengthening the quality and aptitude of the technicians, there are still opportunities for improvement. This is due, in substantial part, to the high rate of turnover in this position at NVMHI. Jane Ryan noted that due to the turnover rate of psychiatric technicians, a "tremendous burden is placed on tenured nursing staff to help these individuals who for the most part are

inexperienced and need to learn how to provide the required nursing care." Even so, those psychiatric technicians who do not meet standards of care must be subject to corrective action. As a result of the failure to provide adequate care to JS and follow proper procedure in his treatment, two psychiatric technicians were terminated following his death.

H. Implement a Plan for Recruitment and Retention of Qualified Personnel

Dr. Kirch observed in July of 1999 that one factor that "very well may outweigh all others in impeding progress" in implementing NVMHI's Plan for Continuous Improvement is high staff turnover. After her most recent visit, Jane Ryan reported that NVMHI had enough nurses and technicians to provide the adequate observation for the FY patient census. However, turnover of both nurses and psychiatric technicians is still rapid. 26% of the psychiatric technicians who resigned during FY99 were also hired during the same year. 23% of the RNs who resigned during FY 99 had also been hired during that same year. As of July 1999, nursing staffing was at or near required levels on all units. However, recruitment and retention continues to be a problem, and turnover is still high. As of August 1999, two of five nurse managers were new within the past year. In order to provide quality care, NVMHI must have adequate staff to execute their duties.

Jane Ryan stated in her report that [t]he psychiatric technicians, who serve a key role in maintaining the therapeutic milieu and patient safety, are reported to be undercompensated and in need of approval of a shift differential. Ryan reported that although NVMHI requested a shift differential for the psychiatric technicians in the FY 2000 budget, DMHMRSAS Central Office turned down the request. According to the NVMHI Director of Nursing, NVMHI has substantial difficulty in recruiting employees who are capable of meeting hospital standards for that position.

I. Fully Implement the Continuous Improvement Plan, with Revisions, as Soon as Possible

NVMHI is in substantial compliance with the Settlement Agreement with the DOJ as of January 1, 2000. Due to numerous changes in facility administration in the past two years, NVMHI has still been unable to institute all of the components of the Plan, which may be in violation of the Agreement. At this time, NVMHI and DMHMRSAS have requested an extension until October 1, 2000 for full implementation of the Plan. DOJ has not yet approved this extension of the Notice Date. DRVD stresses that NVMHI must make all necessary changes as quickly as possible. Such action will significantly improve facility conditions and the care and treatment of persons with mental

illness in Northern Virginia.

J. DRVD will Monitor Implementation of the Remedial Measures Regarding Patient Care

DRVD will monitor implementation of the settlement reached between NVMHI and the Department of Justice regarding the provision of medical care to the patients at NVMHI. DRVD will work closely with the Department of Justice, the Inspector General for DMHMRSAS, the NVMHI administration, and the DMHMRSAS Office of Human Rights on medical care and human rights issues relating to residents of NVMHI and their families.